DECISION-MAKER:		**HEALTH AND WELLBEING BOARD**		
SUBJECT:		**LOCAL SAFEGUARDING ADULTS BOARD'S ANNUAL REPORT**		
DATE OF DECISION:		**30 SEPTEMBER 2015**		
REPORT OF:		**INDEPENDENT CHAIR, LSAB**		
		CONTACT DETAILS		
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STATEMENT OF CONFIDENTIALITY				
None				

BRIEF SUMMARY		
This report introduces the 2014/15 Local Safeguarding Adults Board's (LSAB) annual report.		
RECOMMENDATION:		
	(i)	That the Health and Wellbeing Adults Board's (LSAB) Annual Report be noted in respect of the following:
		• The LSAB was peer reviewed in 2014/15 which concluded its structure and membership ensured it would comply with the new legal duties introduced by the Care Act 2014. The reviewers also praised the good multi-agency ownership at senior level, found partners were being held to account by LSAB and that partners '*contribute equally and fully participated'* and were '*driven to improve and modernise services*.
		• The substantial increase in concerns this year and the changing nature of the types of abuse being reported.
REASONS FOR REPORT RECOMMENDATIONS		
1.	The Department of Health's (DoH) Care and Support Guidance requires that the LSAB have core responsibility for strategies for the prevention or abuse and neglect and, as part of their oversight, understand how this work ties in with the Health and Wellbeing Board (HWBB) approach locally. [pg. 14.111]. The HWBB are therefore asked to consider where there may be opportunities for the HWBB and LSAB to work more closely together, particularly in relation to corresponding functions of both board's e.g. to hold partners to account and gain assurance of the effectiveness of their arrangements and on strategies to reduce incidents of abuse and neglect for adults at risk in Southampton.	
DETAIL (Including consultation carried out)		
2.	The LSAB meets six times a year in order to share learning in relation to pertinent practice issues, examine the effectiveness of each agency's actions in preventing harm to adults at risk and evaluate their ability to identify and address risks when these arise. Outside of these meetings partners work within their own organisations or within the LSAB subgroups to undertake the core statutory functions of the LSAB.	

Comment [CS1]:

3.	In 2014-15 the LSAB's Case Review sub group received 10 referrals for a safeguarding adults review. The LSAB must undertake a review when an adult at risk has died or suffered serious harm and there is reasonable cause for concern about how partners have worked together to safeguard them from harm [s.44 Care Act]. Having reviewed the cases the group made recommendations to the LSAB or, where there was evidence of a single agency failing, sought assurance that the matter would be referred to the appropriate regulatory service and commissioners of services to pursue.
4.	Following the case review group's recommendation the LSAB commissioned a partnership review in one case which, although it did not meet the threshold for a Safeguarding Adults Review, the partnership felt important lessons could be learnt from the case. In addition, the LSAB is working with MAPPA colleagues to review another case where a vulnerable adult died. Both reviews are yet to be concluded and so will be reported in next year's annual report, but the learning from these will inform the work of the Board and partner agencies as soon as it is available.
5.	LSAB's Monitoring and Evaluation sub group play an essential role in collating the multi-agency data for safeguarding activities undertaken by the partners, cross referencing information and identifying trends or spikes throughout the year. In addition the sub group has a detailed programme of qualitative audits to conduct to ensure that the LSAB partners are able to make well informed, evidence based strategic decisions on how best to use resources to prevent or intervene to stop adults at risk from experiencing abuse and neglect.
6.	The LSAB shares the Community Engagement and Awareness sub group and Learning and Development Group with the LSCB, these are recently established and has already led in coordination of awareness campaigns and training opportunities that are promoting a 'think family approach' to interventions. The group is developing a full multi agency safeguarding delivery plan based on the principles agreed in the Workforce Development Strategy for the 4LSAB area. It has also begun its role to quality assure local single agency training as well as mapping what is available for staff in Southampton currently.
7.	In 2014-15 there were 1,363 concerns (previously known as 'alerts') made in relation to adults at risk of abuse or neglect. This is a significant increase of 237% from 2013-14. There were 282 completed enquiries (previously known as referrals or investigations) which is a reduction from the previous year. There is still a high number of repeated concerns (27%) which the LSAB continue to monitor because this may be an indication that screening or early interventions are not as effective as they could be. Concerns were, in the main, raised by professionals working in partner agencies.
8.	It is reassuring that professionals, and particularly those from health services, are increasingly more confident to raise safeguarding concerns, but noteworthy that only 5% of concerns were raised by service users, carers or family members. The LSAB believes this demonstrates much more needs to be done urgently to raise awareness with members of the public about the risks of neglect or abuse and how to report this. A public campaign is a key priority for 2015 and the LSAB will continue to monitor the source of concerns as a measure the impact of these campaigns.

9.	There has been a number of significant changes in the types of abuse being reported. For example, there was an increase in enquiries resulting from physical abuse (up to 48% from 29% last year, which was consistent with national figures). The SAT report that professionals (when either raising concerns or conducting safeguarding investigations) are more confident to identify physical abuse which reflects the impact of the awareness campaigns, led by the LSCB, on zero tolerance of domestic violence within the city. It is also noteworthy that SHFT report that 25% of concerns for their client group relate to physical abuse. The LSAB will work to ensure partners recognises the increased risk of harm posed to vulnerable groups and ensure that partners respond effectively to allegations, including Disability Hate Crime, so that we can demonstrate we are tackling this form of abuse and people feel safer in the city.
10.	There was also a substantial reduction in allegations of neglect and acts of omission (only 8% of all enquiries in 2014-15, against 16% in 2013-14 and much lower than national comparative data of 30%). It also corresponds with a reduction in cases of alleged abuse occurring in care homes (15% in 2014-15 down from 20% for 2013-14 and against 36% nationally) and community social care settings (4% in 2014-15, down from 11% last year). Furthermore, there were no enquiries which identified institutional abuse within Southampton last year, an improvement on the 5 cases investigated the year before. This is as a result of the significant work, detailed within the full report, undertaken by the Integrated Commissioning Unit to monitor and improve provision within the social care sector in the city.
11.	The data also reveals a reduction in financial abuse enquiries from 28% last year to 22% in 2014-15. This is still higher than the national comparator of 18%, but it is also fair to say that this does not reflect the true extent of work undertaken by the partnership to manage the risk of financial abuse and support those who have experienced it. The LSAB, in recognition of the complexity in tackling financial abuse after the event, proposes instead to address this area of risk through a preventative campaign in 2015-16.
RESOURCE IMPLICATIONS	
Capital/Revenue	
12.	The LSAB has agreed a budget for 2014-15 which is funded by the City Council, Southampton City Clinical Commissioning Group and Hampshire Constabulary, all of whom are statutory partners of the LSAB. As this report is for information only, there are no resource implications.
LEGAL IMPLICATIONS	
Statutory power to undertake proposals in the report:	
13.	The Care Act 2014 requires Southampton City Council to establish a LSAB and provides for accountability of the Independent Chair to the Chief Executive of the Local Authority. The DoH's Care and Support Guidance recommends the LSAB work in partnership with the HWBB and this report is to inform HWBB members about the work of the LSAB to assist with this.
POLICY FRAMEWORK IMPLICATIONS None	

KEY DECISION?	No		
WARDS/COMMUNITIES AFFECTED:	All		
SUPPORTING DOCUMENTATION			
Appendices			
1.	LSAB Annual Report 2014-15		
2.	LSAB Strategic Plan 2015		
Documents In Members' Rooms			
1.	None		
Equality Impact Assessment			
Do the implications/subject of the report require an Equality and Safety Impact Assessments (ESIA) to be carried out.			No
Other Background Documents **Equality Impact Assessment and Other Background documents available for inspection at:**			
Title of Background Paper(s)		Relevant Paragraph of the Access to Information Procedure Rules / Schedule 12A allowing document to be Exempt/Confidential (if applicable)	
1.	DoH Care and Support Guidance	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/366104/43380_23902777_Care_Act_Book.pdf	